After the Navy, Casey was not finished by a long shot. He and his wife decided it was time to work, to hunker down and make a little money. Throughout the 1970s and 1980s and early nineties Casey and Dickey both became hard working real estate agents and brokers in the greater Northern Virginia area. Casey had a very successful second career in land development and commercial and industrial real estate.

My personal relationship with Casey goes back for more than 25 years. During that time he visited my home State of Alaska many times. In fact, as a great campaign supporter and worker he rightfully credits himself with more than one of my narrow campaign victories.

As a young man Casey was a scratch golfer and later carried a single digit handicap for years. Over 30 years a member of the Army-Navy Country Club, Casey can still break 90 on a regular basis.

Even as he approaches his 80 years young this Fourth of July, Casey is as active as ever. He works out three times a week, stays in excellent shape, maintains a delightful sense of humor, and still drinks his vodka on the rocks, sports a license plate that declares life is too short to smoke cheap cigars. God willing, my wife Lu and I will have many more years of close friendship to look forward to with this very special man and his very special family.

As I recollect on the meaning of July 4, I will, along with many other friends and family, celebrate on that day the birth of a particularly good friend, an American hero who was willing to give his all to our Nation.

Mr. Speaker, please join my colleagues and me in wishing a very happy 80th birthday to Captain Curtis J. Zane, United States Navy Retired. Happy birthday, Casey. You are my sweetheart.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for the balance of the majority leader's hour.

Mr. GANSKE. Mr. Speaker, I plan to talk about three things concerning health care, the status of managed care reform legislation, the problem of the uninsured and access to health care, and briefly, some problems with the Medicare Reform Act of 1997.

Mr. Speaker, another week has gone by without health care reform reaching the floor of the House of Representatives. As Yogi Berra would say, it is deja vu all over again. Why do I say that? Last year we debated an HMO reform bill on this floor that was drafted in the middle of the night by the HMO lobbyists and should have been labeled ''the HMO Protection Act of 1998.''

Last week in the Committee on Education and the Workforce components of last year's sadly deficient HMO bill were debated again. Members would think that since we passed decent HMO legislation for Medicare in 1997 dealing with HMO gag rules that prevent doctors from telling patients all their treatment options, that it would not be too difficult to duplicate that for everyone.

No, on the Committee on Education and Workforce, the subcommittee bill's rules of construction suggested that a plan's own guidelines can still be enforced, even if they have the effect of preventing full and open communication between patients and their health care providers.

Members would think that the subcommittee bill's provisions on emergency care could simply mirror what we passed for Medicare in 1997. After all, if it is good enough for seniors, it should be good enough for the rest of us, right? Well, not according to the K Street lobbyists who wrote this provision, too.

The subcommittee bill, as passed last week, narrows the prudent layperson definition so that patients would only be covered for an initial but undefined appropriate screening examination. For all other services, including potentially lifesaving treatments, emergency physicians would have to certify in writing that the patient needed immediate emergency medical care.

□ 1745

Now, think of that for a moment. In the middle of saving a patient's life, an ER doc is supposed to write a letter to an HMO. Just how long would it take for the HMO to get that letter? I would not recommend holding one's breath.

This new HMO protection bill would then make the plan cover such care only if retrospectively the plan itself agreed to. Furthermore, patients in severe pain would not be fully protected under the Committee on Education and the Workforce subcommittee bills.

What about a man or a woman whose only symptom of a heart attack is crushing chest pain? This type of patient protection is a joke. This is just another example, and on a simple issue at that, of trying to look like one is for patient protection when one is really only looking for a fig leaf.

But the bills that passed the subcommittee last week are not just bad bills, they would actually make it harder for patients to fight HMO abuses under ERISA, the Employee Retirement Income Security Act. For instance, one of the Committee on Education and the Workforce bills, the Group Health Plan Review Standards Act of 1999, requires that group health plan's arbitrary definitions and guidelines be followed throughout the review process when determining medical necessity.

Thus, the bills fail to address what we would call the smart bomb of HMOs, and that is their ability under ERISA to justify any decision they want in denying care, even if that care is well within prevailing standards of medical care.

Now, Mr. Speaker, I have spoken many times on this floor about how important it is for patients to have care that fits prevailing standards of medical care. Let me give my colleagues an example. One particularly aggressive HMO defines medically necessary as the cheapest, least expensive care, quote-unquote. So what is wrong with that, my colleagues say?

Well, take a look at this child. Prior to coming to Congress, I cared for children with this defect, cleft lip and palate. The prevailing standard of care for this defect, this birth defect is surgery. But according to that HMO's definition to give the cheapest, least expensive care, he could use his own definition under current Federal law to justify using a piece of plastic to fill in the roof of this child's mouth. After all, that would be the cheapest, least expensive treatment.

Of course, the child would not speak as well. If the plastic obturator fell out, he would get food and his drink coming out of his nose. But of what difference is that to the HMO since they are providing the cheapest, least expensive care?

This Committee on Education and the Workforce bill would, not only fail to correct that travesty, but it would move in the opposite direction by permanently stopping the development of ERISA case law that has slowly been forcing plans to account for negligent decisions.

This bill violates the dictum that all who treat patients learn early in their training, ''primum non nocere'', first do not harm. I urge my colleagues on the Committee on Education and the Workforce to remember that dictum. I urge the Committee on Education and the Workforce chairman to work with the gentlewoman from New Jersey (Mrs. ROUKEMA) and the gentleman from Georgia (Mr. NORWOOD) to adopt real patient protections.

Fortunately, enough of my Republican colleagues on the Committee on Education and the Workforce have joined their Democratic committee members and have forced the chairman to delay the full committee markup of those HMO industry bills. Maybe if the Members of that committee hear from enough of their concerned consumers back home, they may yet come up with some legislation worthy of the name ''patient protection.''

Mr. Speaker, common sense proposals to regulate managed care plans do not constitute a rejection of the market model for health care. In fact, they are just as likely to have the opposite effect, to preserve the market model by saving it from its most destructive tendencies.

Surveys show that there is a significant public concern about the quality of HMO care. If these concerns are not addressed, I think that it is likely that the public will ultimately reject the market model. However, if we can enact true managed care reform such as that embodied in my own Managed

Care Reform Act of 1999, or the bill of the gentleman from Michigan (Mr. DINGELL) or the bill of the gentleman from Georgia (Mr. NORWOOD), then consumer rejection of a market model is less likely.

Mr. Speaker, this is not a novel situation. Congress has stepped in to correct abuses in many industries. That is why we have child labor laws and food and drug safety laws. That is why Teddy Roosevelt broke up the trusts. Those laws, in my opinion, helped preserve a free market system. Congress would not be dealing with this issue were it not for past law enacted by Congress.

For a long time, Congress had left insurance regulation to the States. By and large, the States have done a pretty good job. But Congress passed a law called the Employee Retirement Income Security Act, known as ERISA, some 25 years ago to simplify pension management.

Almost as an afterthought, employer health plans were included in the exemption from State law. Unfortunately, nothing was substituted for effective oversight in terms of quality, marketing, or other functions that State insurance commissioners or legislatures have effectively done.

That lack of oversight, coupled with lack of responsibility for medical decisions that they make, has led to many tragedies. Let me tell my colleagues about just one example.

This is little Jimmy Adams tugging on his sister's shirt sleeve before his HMO health care. About 3 weeks or so after this picture was taken, at 3:30 in the morning, Lamona Adams, Jimmy's mother, found Jimmy sweating, panting, moaning. He had a temperature of over 104. So she phoned her HMO to ask for permission to go to the emergency room.

The voice at the other end of the 1–800 number told her to go to Scottish Rite Hospital. Where is it, asked Lamona. I do not know; find a map, came the reply. It turns out that the Adams family lived south of Atlanta, Georgia, and Scottish Rite was an hour away on the other side of the Atlanta metro area.

Lamona held little Jimmy in her arms while dad drove as fast as he could. Twenty miles into the trip, Mr. and Mrs. Adams passed Emory University Hospital's emergency room. They passed the emergency room at Georgia Baptist. They passed Grady Memorial's emergency room. But they pushed on to Scottish Rite Medical Center, still 22 miles away, because they knew that, if they stopped at one of those unauthorized hospitals, they would get stuck with the bill.

They also knew that Jimmy was sick. They just did not know how sick he was. I mean, after all, they were not trained medical professionals.

With miles yet to go, Jimmy's eyes fell shut, and they would not open. Lamona franticly called out to him, but he did not awaken. His heart had stopped. Imagine Jimmy's dad driving as fast as he could while Lamona is trying to keep her little 6-month-old baby alive.

They finally pulled into the emergency room. Lamona leaped out of the car screaming, ''help my baby, help my baby.'' A nurse rushed out, gave him mouth-to-mouth resuscitation. They brought out the crash cart. They started the lines. They intubated him. They gave him medicines. They did everything that modern medicine could do to save this little infant.

Well, Jimmy was a tough little guy. He survived despite the delay in his emergency care caused by that medical decision by his HMO which told him to go a long ways and not go to the nearest emergency room. But he did not end up whole.

Because of that cardiac arrest caused by that HMO's decision, Jimmy ended up with gangrene in both hands and both feet. The doctors had to amputate both of Jimmy's hands and both of Jimmy's feet. This is Jimmy after his HMO health care.

Well, today, Jimmy is learning to put on his leg prostheses with his arm stumps. But it is tough for him to get on his bilateral arm hooks by himself.

The HMO industry calls victims like this ''anecdotes.'' Well, this little anecdote will never play basketball. He will never be able to caress the cheek of the woman that he loves with his hand. I will tell my colleagues this little anecdote, if he had a finger, and one pricked it, it would bleed.

Jimmy's mom and dad tried to get care for him. They followed their HMO's instructions. They phoned their gatekeeper. The problem was they were dealing with a managed care system that emphasizes cost over quality.

Lamona never spoke to a doctor when she called at 3:30 in the morning. They were not allowed to speak to a doctor, nor were they allowed to go to the nearest ER with what a layperson would have said surely was a true emergency.

A judge looked at the case of James Adams and said this HMOs margin of safety was ''razor thin'', and I would add to that about as razor thin as the scalpel that had to amputate little Jimmy's hands and feet.

Well, under current Federal law, this funny law called ERISA, if one receives one's insurance from one's employer, and one has a tragedy happen to one's family like happened to little Jimmy Adams, one's HMO that has made that decision is liable for nothing. That is right, nothing. Congress created this law, ERISA, with a loophole that prevents health plans from being responsible for the tragedies that they create like that that happened to little Jimmy Adams.

The Ganske Managed Care Reform Act of 1999 would help prevent a case like this. It would also make health plans responsible for their actions. So to my Republican colleagues, I call out, we Republicans talk about people being responsible for their actions. I have heard on this floor many times that we think we Republicans think that a murderer or a rapist should be responsible for his actions. We think an able-bodied person should be responsible for providing for his children. Well, my fellow Republicans, HMOs should be responsible for their actions, too. Let us walk the walk on responsibility when it comes to HMOs, just as we do for criminals, and deadbeat fathers.

Mr. Speaker, opponents to real managed care reform always try to inflate fears that this legislation will cause premiums to go up, that people will be priced out of coverage. Not so. Studies have shown that the price of managed care reform would be minimal, probably less than $35 a year for a family of four.

In fact, the CEO of Iowa's Blue Cross Wellmark told me that they are implementing HMO reforms, and they do not expect to see any premium increases from those changes.

Now, the HMO industry last year spent more than $100,000 per Congressman lobbying on this issue and has been running ads all around the country claiming larger costs for this legislation. I advise my colleagues to take their numbers with a grain of salt.

The industry took an estimate of last year's Patients' Bill of Rights, which was scored by the Congressional Budget Office at 4 percent cumulative increase over 10 years, but the industry reported the increase as if it were 4 percent annually.

The HMO industry also conveniently ignored page 2 of the Congressional Budget Office summary, which said that only about two-thirds of that 4 percent over 10 years would be in the form of raised premiums. Yes, the HMOs predict dire consequences if Congress passes a bill like my Managed Care Reform Act of 1999. They say lawsuits will run rampant. They say costs will skyrocket, that managed care will shrink.

Well, Mr. Speaker, these Chicken Littles remind me of the opponents years ago to legislation to clean water, to clean air a decade ago. At that time, they said the sky will fall, the sky will fall if that legislation is passed. Instead, what do we have today, Mr. Speaker? We have clean air, and we have clean water at a reasonable cost.

So let us look at the facts as they relate to this HMO legislation. In Texas, after a series of highly publicized hearings during which numerous Texans told of injury or death resulting from denial of treatment by their HMOs, the Texas Senate passed a strong HMO reform bill, making HMOs liable for their medical decisions by a vote of 25 to 5.

☐ 1800

The Texas House passed that bill unanimously. And under Governor George W. Bush, that bill became law in May 1997.

Yesterday, in the House Committee on Commerce, we heard testimony

from Texans that refutes those dire predictions by the HMOs. A deluge of lawsuits? There has been one lawsuit in the 2 years since passage of the Texas Managed Care Liability Act. That lawsuit, Plocica v. NYLCare, is a case in which the managed care company did not obey the law and a man died because of that. This case exemplifies why we need accountability at the end of external review.

Mr. Plocica was discharged from the hospital suffering from severe clinical depression. His treating psychiatrist informed the HMO that he was suicidal and that he needed additional hospitalization until he could be stabilized. Texas law requires an expedited review by an independent review organization prior to discharge. Such a review was not offered by the plan. Mr. Plocica's wife took him home. During the night he went to his garage, he drank antifreeze, and he died a horrible, painful death.

That case shows that external review and liability go hand in hand, Mr. Speaker. Without the threat of legal accountability, HMO abuses, like those that happened to little Jimmy Adams or to Mr. Plocica, will go unchecked. But a lesson from Texas also is that lawsuits will not go crazy. In fact, when HMOs know that they will be held accountable, there will be fewer tragedies like these.

And just as there has not been a vast increase in litigation, neither has there been skyrocketing increases in premiums in Texas. The national average for overall health care costs increased 3.7 percent in 1998, while the Dallas and Houston markets were well below average at 2.8 percent and 2.4 percent respectively. Other national surveys show Texas premium increases to be consistent with those of States that do not have the extensive patient protections passed by the Texas Legislature.

And the managed care market in Texas certainly has not shrunk. In 1994, the year prior to the Texas managed care reforms, there were 30 HMOs in Texas. Today there are 51. In a recent newspaper article, Aetna's CEO Richard Huber referred to Texas as the filet mignon when asked about Aetna's plans to acquire Prudential. None of these facts support the HMOs' accusations that the Texas patient protection laws would negatively impact on the desires of HMOs to do business in Texas.

Perhaps all of the above is why Governor George W. Bush personally told me that he thinks that Texas patient protection laws are working ''pretty good'' in his State.

It is time for this Congress to get off its duff, to fix this problem which it created when it took health insurance oversight away from States two decades ago. I call on my Republican colleagues to bombard our leadership with demands that this legislation be brought to the floor in the next 4 weeks for a fair debate. A fair debate is already long overdue.

I would tell my colleagues that just half an hour ago I had a talk with the Speaker of the House, the gentleman from Illinois (Mr. HASTERT). I begged him to bring this legislation to the floor, and he assured me that we will have a debate on the floor here in Congress, in the House of Representatives, by the middle of July. That is his intent. So, Mr. Speaker, I am anxiously awaiting.

Now, Mr. Speaker, let me talk for a minute about the uninsured, because I think Congress should address this issue, and I have some thoughts on this important issue.

First of all, who are the uninsured? Well, there are about 43 million people without any form of health insurance coverage. About 25 percent of the uninsured are under the age of 19, 25 percent are Hispanic, 25 percent are legal noncitizens, 25 percent are poor, which is noteworthy because 46 percent of the poor do not have Medicaid even though they qualify. These groups overlap so that if someone is below the age of 19, Hispanic, poor and a legal noncitizen, the chances of being uninsured are very high. A significant proportion, however, are not poor and have incomes more than two times the poverty level, but these people tend to be aged 19 to 25. Fewer than 15 percent of those older than 25 do not have health insurance.

Well, knowing these facts, a few solutions to help solve the problem of the uninsured should be obvious. First, there are 11 million uninsured children living in this country, one-quarter of the uninsured. About 5 million of those children qualify for Medicaid or for the Children's Health Insurance Program, known as CHIP, but they are not enrolled. They are not enrolled.

Hispanic Americans represent 12 percent of the under-65 population, but 24 percent of the uninsured. The income of many Hispanics qualifies them for Medicaid, but they, too, are frequently not getting health coverage they are qualified to receive. Why? Because the government bureaucracy has made it difficult for families to access the system.

In my own State of Iowa, the application is not only long, but a Medicaid recipient must report his income each month in order to get Medicaid. I encourage my colleagues back in the State of Iowa to correct this.

In Texas, to be eligible for Medicaid, the uninsured must first apply in person at the Department of Human Services, usually located way off the beaten track and out of range of public transportation. And if even one of the receipts to prove eligibility is forgotten, the applicant then has to spend another day traveling and waiting in line.

In California, the uninsured person who is poor must first fill out a 25-page application for Medicaid, often in a language the applicant can barely read. In fact, English is frequently a second language.

So the first thing we can do to reduce the number of the uninsured is to make sure that the poor who qualify for Medicaid are, in fact, receiving Medicaid. Simplify forms, reach out to the Hispanic and other ethnic communities and oversee the CHIP program to see why more people who qualify are not taking advantage of that program. In many cases it is as simple as the uninsured not knowing about the programs.

What about those aged 19 through 23? Many are in college. This is a healthy group. They should be inexpensive to cover. Some colleges say they can cover these people for only $500 a year for a catastrophic insurance plan. That is a small price to pay compared to tuition. I know, I have a daughter in college. So why have we not made a commitment to health care coverage for that group? Maybe we should look at tying student loans to health coverage.

I do believe that tax policy also determines to some extent whether an individual has health insurance. Businesses get 100 percent deductibility for providing health care to employees. Individuals purchasing their own insurance should get the same treatment. This would lower the cost of insurance for many.

But, Mr. Speaker, in trying to address the uninsured, Congress should be very careful not to pass legislation that could actually increase the number of uninsured through unintended consequences of potentially harmful ideas such as health marts and association health plans.

Let me explain my concern. Under court interpretations of the Employee Retirement Income Security Act, ERISA, State insurance officials cannot regulate health coverage by self-insured employers. This regulatory loophole created many problems with the association health plans. The benefit of being able to create a favorable risk pool motivated many to self-insure, but without the discipline of State insurance oversight, many of the association health plans became insolvent during the 1970s and the early 1980s, and they left hundreds of thousands of people stranded without coverage.

Some of those plans went under because of bad management and financial miscalculations. Remember, they did not have insurance regulatory oversight. Others were started by unscrupulous people whose only goal was to make a quick buck and to get out without any concern about the plight of those covered in those ''association plans.'' I would encourage my colleagues to read Karl Polzer's article ''Preempting State Authority to Regulate Association Plans: Where Might It Take Us.'' It is in National Health Policy Forum, October 1997.

My colleagues, those who do not know history are bound to repeat it. The rash of failures led Congress in 1983 to amend ERISA, to give back to the States some of that authority to regulate self-insured, multiple-employer welfare associations or AHPs, association health plans. Only self-insured plans established or maintained by a

union or a single employer remained exempt from insurance regulation.

Unfortunately, there are now those who want to ignore the hard lessons of the past. They want to repeat the mistakes of pre-1983. If anything, some mismanaged and fraudulent associations continue to operate. Some associations try to escape State regulation by setting up a sham union or sham employer associations. Then they self-insure, and then they claim they are not an MEWA, a multiple-employer welfare association.

To quote an article by Wicks and Meyer in an article called ''Small Employer Health Insurance Purchasing Arrangement: Can They Expand Coverage?'': ''The consequences are sometimes disastrous for people covered by these bogus schemes.'' If anything, Mr. Speaker, Congress should crack down on these fraudulent activities, not promote them.

Wicks and Meyer summarized the two big problems with expanding ERISA exemption to association health plans. First, if they bring together people who have below-average risk, and they exclude others, and they are not subject to small group rating rules, then they draw off people from the larger insurance pool, thereby raising premiums for those who remain in the pool.

Second, if they are not subject to appropriate insurance regulation to prevent fraud and to ensure solvency and long-run financial viability, they may leave enrollees with unpaid medical claims and no coverage for future medical expenses. Mr. Speaker, that certainly would not help the problem of the uninsured.

I recently asked a panel that appeared before the Committee on Commerce if they agreed with those concerns that I just mentioned about association health plans, and they unanimously did. And that panel even included proponents of association health plans.

Mr. Speaker, let us pass real HMO reform legislation. Let us learn from States like Texas. After all, is it not Republicans who say that the States are the laboratories of democracy? Let us address the uninsured by making sure that those who qualify for the safety net are actually enrolled. And, yes, let us have equity in health insurance tax incentives, but let us also be wary of repeating past mistakes with ERISA.

And, finally, Mr. Speaker, I want to talk briefly about Medicare as it relates to access to health care for all of us. In 1997, Congress passed and the President signed the Balanced Budget Act. In that bill were provisions to slow the growth of Medicare expenditures in order to extend the solvency of that trust fund.

□ 1815

But Mr. Speaker, the effect of that bill on our rural and teaching hospitals is more profound than what was anticipated. We are not seeing just slowed growth rates for our rural and teaching hospitals. We are seeing real and significant cuts.

A survey in Iowa found that Medicare's lower reimbursement will cost small rural Iowa hospitals on the average to lose $1 million each in the next 5 years. Larger rural hospitals will lose between $2 million and $5 million. And urban teaching hospitals will lose between $10 million and $40 million.

The University of Iowa hospitals and clinics is projected to lose $64 million over 5 years. And this is in Iowa, with one of the lowest reimbursement rates in the country.

Let me give my colleagues some specific examples for hospitals in Iowa. Current payment to Iowa rural hospitals for cataract operations is about $1,300. The proposed payment will be $980, a 30-percent reduction, not just a ''reduced rate of growth.''

A rural hospital in Iowa today receives about $500 for a colonoscopy. The proposed payment will be $300, a 40-percent reduction. Medicare today pays about $45 for a mammogram to rural hospitals. The future payment will be $30. And this is happening in rural and teaching hospitals everywhere in this country.

The Washington Post just published an article that Georgetown University Hospital is projected to lose $75 million because of the 1997 Balanced Budget Act. This hemorrhage in our rural and teaching hospital will cause some to fail. This will certainly not help people's access to care.

If a county seat town in Iowa loses its hospital, it will lose its doctors and the town itself will start to fade away. And I am sure that my colleague from Vermont would say the same thing about Vermont.

Mr. Speaker, I took a lot of heat from my colleagues back in 1995 when I pointed out that $250 billion in Medicare reduced payments would severely hurt health care. Fortunately, arguments like mine were able to scale back the cuts. However, it is now clear that Congress needs to restriction adjust that bill. There are reports that the savings from that legislation are significantly greater than anticipated.

Now, I am not talking about a wholesale rewrite of the Medicare bill, because a lot of it is working well. Reducing payments to HMOs was a positive. In fact, a recent GAO report shows that HMOs are still being overpaid because they select healthy seniors and they shed the sick. However, we ought to be able to afford some adjustments for our rural and teaching hospitals.

After all, Mr. Speaker, what good does it do to have insurance, whether private or Medicare, if we do not have a hospital to go to if we are sick?

Let us not bury our heads in the sand about either HMO abuses or this Medicare problem, or I will guarantee my colleagues, Mr. Speaker, the people in the next election will remember.

I am anxiously awaiting a fair and a complete debate on this floor. We owe it to the Jimmy Adamses in our country.

YOUNG AMERICANS MUST PARTICIPATE IN POLITICAL PROCESS

The SPEAKER pro tempore (Mr. DEMINT). Under the Speaker's announced policy of January 6, 1999, the gentleman from Vermont (Mr. SANDERS) is recognized for 60 minutes as the designee of the minority leader.

Mr. SANDERS. Mr. Speaker, it has always seemed to me that the major crisis that we face as a country is not that we do not know the answers to the most serious problems that we face but rather, for a variety of reasons, we refuse to ask the right questions.

As the only independent in the Congress, I want to raise some issues that are usually ignored by most of my Democratic colleagues and most of my Republican colleagues and are often ignored by the mass media, as well.

Let me start off with one question that I think is the most important of all; and that is, why is it that tens and tens of millions of people in our country, most especially the young people, are giving up on the political process? Why is it that virtually every day we become a less and less democratic and participatory society? Why is it that in the last election, in November of 1998, only 36 percent of the American people bothered to vote, which was the lowest turnout that we have had in many years? And this compares, as my colleagues know, Mr. Speaker, with the recent election that took place in Israel, where 90 percent of the eligible people voted, compared to 36 percent in the United States.

It is not uncommon in Canada, in Europe, in Scandinavia to have elections in which 70 or 80 or 90 percent of eligible voters participate.

Why is that? Why is that that so many people say, ''oh, democracy, oh, voting, oh, participating in the political system, do not be silly. I would not think of doing that.''

Now, as bad as the general situation is, as bad as a 36-percent voter turnout is, what is even worse and more frightening is that, in the last election, if my colleagues can believe it, only 18 percent of the young people under 24 years of age voted. That means 82 percent of people 24 years of age or younger did not vote. And that in itself is a very serious situation.

But what is even more frightening is that we know that, by and large, if people do not vote and participate when they are young, they are much less likely to vote as they age. So that means that, everything being equal, as low as our voter turnout is right now, it is likely that in years to come it will become even lower.

Now, not only is the voter turnout among young people distressingly low, but what is also very frightening is that polls indicate that young people know very little about the political